MH 556
Revised 09/28/15

OUTPATIENT MEDICATION REVIEW

I have talked with my psychiatrist or nurse practitioner, _____, who has recommended that I / my child receive(s) medication(s) to treat symptoms of: _____

_____

The type(s) of medications prescribed is checked below:

Medication(s)	**Type** Antidepressant, Anxiolytic, Mood, Stabilizer, Antipsychotic, Other	**Dosage** (including PRN)	**Frequency**	**Method** (Oral/Injection)	**Duration**
1.					
2.					
3.					
4.					
5.					
6.					

I understand the dosage(s) and when to take the medication(s), and that any changes in medication dosage and/frequency during the course of treatment will be discussed with me.

I have been informed that some side effects are possible, including:

☐ Muscle stiffness/tremor ☐ Drowsiness ☐ Dry mouth/blurred vision/constipation
☐ Nausea/appetite changes ☐ Sexual problems ☐ Pregnancy issues ☐ Dizziness
☐ Interactions with other drugs, food & health conditions ☐ Diabetes ☐ Weight Gain
☐ Other _____

I understand that these are common side effects, and that there may be other less common ones. I also understand that I should promptly inform my psychiatrist or other staff member about changes in my condition (e.g. dizziness, severe sedation, rash), if I become pregnant, and/or any new medications I may be prescribed for other conditions.

With some anti-psychotics I understand that there is a possible side effect, tardive dyskinesia, which may cause involuntary movement of the tongue, face, neck, limbs, or torso and may persist even after stopping the medication.

I understand that the decision to take medication is up to me, but that I should always first discuss with my psychiatrist any decision to stop taking medication.

I understand that my psychiatrist believes this medication will help me, but there is no guarantee as to the results.

☐ **I HAVE READ THIS FORM** ☐ **THIS FORM HAS BEEN READ TO ME**

☐ **THIS FORM WAS INTERPRETED IN _____FOR ME.**

If a translated version of this Form was signed by the client and/or responsible adult, the translated version must be attached to the English version.

THE INFORMATION ON THE FORM HAS BEEN EXPLAINED TO ME , AND I AGREE TO TAKE THE MEDICATION(S) AS PRESCRIBED.

Signature: _____ **Signature: _____**
(Client) (Parent/Legal Guardian/Conservator)

I HAVE EXPLAINED THE BENEFITS, SIDE EFFECTS AND RISKS OF THE MEDICATION(S) LISTED ABOVE AND HAVE OBTAINED THE PATIENT'S/RESPONSIBLE ADULT'S INFORMED CONSENT.

Signature: _____ **Date: _____**
(Psychiatrist or Nurse Practitioner and Discipline)

Name: **DMH ID#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

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